A F F I D A V I T

I, Brian Hill, Special Agent (SA), Department of Health and Human Services, Office of Inspector General, Office of Investigation (HHS), being first duly sworn, hereby depose and say:

I. Introduction

1. My law enforcement experience began in 1995 when I started working as a police officer in Raytown, Missouri. During the six and a half years I was there, my duties included working in the Patrol Division and on the Jackson County Drug Task Force (JCDTF-Narcotics Division). My three and a half years of experience on the JCDTF included work as an undercover officer where I acquired extensive experience authoring and executing arrest and search warrants. After leaving the Raytown Police Department, I spent three years working in the Patrol Division and Judicial Protection/Court Security Division of the Jackson County Sheriff's Department. I have been a SA with HHS since May 2005.

2. I hold numerous law enforcement certifications with over 2,300 hours of law enforcement continuing education. In August 2005 I successfully completed the Criminal Investigator Training Program at the Federal Law Enforcement Training Center in Brunswick, Georgia. My college education includes a Bachelor of Arts degree in History and Political Science from Kansas Wesleyan University, a Bachelor of Science degree in Criminal Justice/Law Enforcement from Washburn University, and a Master of Arts Degree in Social Science from Baker University.

3. I am currently assigned to conduct investigations involving fraud, waste and abuse in programs administered by the United States Department of Health and Human Services, particularly Medicare. The information in this affidavit is based on my personal knowledge as well as information provided to me by other law enforcement agents and agencies. This affidavit does

not include each and every fact and detail known concerning this investigation, but instead sets forth only the material facts I believe are necessary to establish probable cause in support of a criminal complaint charging the following three persons with the federal felony crime of health care fraud, a violation of 18 U.S.C. § 1347:

Kenneth Agugua	**Faith Agugua**
DOB xx/xx/1959	**DOB xx/xx/1972**

II. Overview of the Scheme to Defraud Medicare

4. Kenneth Agugua and Faith Agugua, as the owners and/or operators of a medical supply company known as Primecare Management, Inc., billed Medicare for the most expensive standard power wheelchair reimbursable by Medicare. After receiving approximately $4,000 from Medicare for each of these power wheelchair claims, the Aguguas frequently would provide the Medicare beneficiary with a "scooter" that was much less expensive than the power wheelchair that had been billed to and paid for by Medicare. Billing Medicare for a more expensive service than the one actually provided is a type of fraud scheme known as "upcoding." The preliminary loss attributable to this "upcoding" scheme is more than $100,000.

III. The Participants in the Scheme to Defraud Medicare

5. **Kenneth Agugua.** According to records form the United States Bureau of Immigration and Customs Enforcement (BICE), Kenneth Agugua was born on xxxxxxx, 1959 in Nigeria. He initially entered the United States on February 8, 1997, and he became a permanent resident alien on January 8, 2002.

6. Kenneth Agugua has a current Missouri State ID card, no. xxxxxxxxxx, that expires on xxxxxxx, 2012, and shows a residence address of xxxxxxxxxxxxxxxxxx, Kansas City,

Missouri xxxxx. Jackson County, Missouri 2005 tax records also show Agugua residing at xxxxxxxxxxxxxxxxxx, Kansas City, Missouri xxxxx. Kenneth Agugua also has a current Texas driver's license, no. xxxxxxxx, expiring on xxxxxxx, 2011, and listing his residence address as xxxxxxxxxxxxxxxxxxxxxx, Houston, Texas xxxxx.

7. **Faith Agugua.** Faith Agugua's full name is Faith Chika Agugua. According to records from BICE, Faith Agugua was born on xxxxxxxxxxx, 1972 in Nigeria and she is a lawful permanent resident alien residing in the United States. Faith Agugua has two current Texas driver's licenses, no. xxxxxxxx and no. xxxxxxxx, both expiring on xxxxxxxxxx, 2006, and both listing her residence as xxxxxxxxxxxxxxxxxxxxxxx, Houston, Texas xxxxx.

IV. The Durable Medical Equipment Company

8. **Primecare Management, Inc.** According to records from the Secretary of State for the State of Missouri, Primecare Management, Inc., was incorporated in the State of Missouri on June 18, 2003. The business address listed for Primecare is xxxxxxxxxxxxxxxxx, xxxxxxxxx, Kansas City, Missouri xxxxx; Martin Okpareke is listed as the sole incorporator and the registered agent for service of process; Faith Agugua is listed as the only corporate director. The telephone for Primecare is xxxxxxxxxxxxxx and the facsimile number is xxxxxxxxxxxxxx.

9. On June 24, 2003, Faith Agugua signed a CMS-855S Application on behalf of Primecare which stated that Faith Agugua was the owner, manager, and administrator of Primecare; that Primecare's Employer Identification Number was xxxxxxxxxx; that its business address was xxxxxxxxxxxxxxxxx, xxxxxxxx, Kansas City, Missouri xxxxx; and that the primary nature of its business was durable medical equipment.

10. According to records obtained from the company that leases xxxxxxxxx to Primecare, the lease for xxxxxxxx was originally registered to Martin Okpareke and was subsequently signed by Kenneth Agugua.

V. Medicare's Motorized Wheelchair Program

11. Medicare is a federally funded health insurance program designed primarily for the elderly and certain disabled persons. There are several components to the Medicare program but the only component that is relevant to this affidavit is referred to as Part B.

12. Part B covers the cost of physicians' services and certain other services such as durable medical equipment[1] and laboratory tests. Part B will pay claims submitted by medical providers who certify that they performed a reasonable and medically necessary service to an eligible patient. Claims for Part B services are billed using a CPT procedural code.[2]

13. Medicare is a typical insurance program. For Part B coverage, beneficiaries pay monthly premiums that are automatically deducted from their Social Security benefits. The plan calls for Medicare to pay 80% of the allowed amount, and the patient (or the patient's supplemental

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[1] Durable Medical Equipment is equipment which (a) can withstand repeated use, and (b) is primarily and customarily used to serve a medical purpose, and (c) generally is not useful to a person in the absence of illness or injury, and (d) is appropriate for use in the home [DMERC Region D Supplier Manual, Chapter 9, Page 3, Revised 01/01]. Durable medical equipment includes motorized wheelchairs.

[2] CPT Codes, which are often referred to as procedure codes, are utilized by CMS (and the carriers) in determining payments. Most procedure codes are published by the American Medical Association (AMA) in what is known as the Physicians' Current Procedural Terminology Manual, or CPT Manual (copyright by the AMA). The CPT Manual is a listing of descriptive and identifying codes for reporting medical services and procedures performed by qualified medical personnel. These procedure codes are used when filing Medicare claims to indicate which medical services the provider performed. When a service or item is not contained in the CPT Manual, local carriers create codes for providers to use.

or Medigap insurance) is responsible for paying the remaining 20%, which is referred to as the copay amount or patient responsibility.

14. Medicare contracts with private insurers to process and pay claims for durable medical equipment submitted under Part B. These entities are known as "Durable Medical Equipment Regional Carriers" or DMERCs.

15. CIGNA Healthcare in Nashville, Tennessee, is the DMERC that processed the claims submitted by Primecare. According to CIGNA, Primecare submitted claims to CIGNA electronically, which were received by CIGNA in Nashville, Tennessee. According to CIGNA, Primecare was reimbursed for claims electronically as well. Electronic funds were initiated on behalf of CIGNA from its bank, JP Morgan Bank, located in Tampa, Florida, and were electronically delivered to Primecare's bank account, which was located outside the state of Florida. Because funding for the Medicare program comes from federal tax dollars, the operation of the Medicare program through the payment of these claims by CIGNA necessarily affects commerce through the interstate movement of federal funds. Thus, Medicare qualifies as a "health care benefit program" as defined by 18 U.S.C. § 24(b).[3]

16. A supplier is an entity or individual that provides, sells or rents durable medical equipment, prosthetics, orthotics or supplies (DMEPOS) to Medicare beneficiaries and meets the supplier standards described on a CMS-855S form.

17. The CMS-855S - Medicare Federal Health Care Provider/Supplier Enrollment Application Form - is used to ensure that the Medicare program is in compliance with all regulatory

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[3] 18 U.S.C. § 24(b) defines "health care benefit program" as "any public or private plan or contract, affecting commerce, under which any medical benefit, item or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract."

requirements. The information collected in the application is used to ensure that payments made from the Medicare trust fund are paid only to qualified DMEPOS suppliers and that the correct amounts are paid. The information also identifies whether the DMEPOS supplier is qualified to furnish health care items to Medicare beneficiaries.

18. The CMS-855S application contains a caution statement directed toward the user about providing fraudulent information.

> I understand that any deliberate omission, misrepresentation or falsification of any information contained in the application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on the application form, may be punished by criminal, civil or administrative penalties including, but not limited to, the revocation of Medicare billing number(s), and/or the imposition of fines, civil damages and/or imprisonment.[4]

By signing the CMS-855S application, the applicant acknowledges he read and understood the penalties for falsifying information as printed on the application.

19. The completed CMS-855S application forms are submitted to the National Supplier Clearinghouse (NSC), which is the national entity contracted by Medicare that issues DME supplier authorization numbers. The NSC receives applications by mail at one of the following locations: 2300 Springdale Drive, Camden, South Carolina 29020 or P.O. Box 100142, Columbia, South Carolina 29202.

20. Once applicants become suppliers, they become ultimately responsible for ensuring they understand the procedures on how to submit claims to CIGNA correctly. The DMERC Region D Supplier Manual states in part:

> You must read your supplier manual and any Medicare publications, including updates to policies and procedures. You are responsible for

[4] CMS 855S Application, Revised 11/01.

> understanding the information contained in these documents and for letting us know if you do not receive a scheduled edition of the supplier bulletin. [5]

Suppliers have access to all the resources necessary to legally present claims for payment. These resources are provided by CIGNA at their website, www.cignamedicare.com. Suppliers may also contact CIGNA telephonically for any questions they may have about these procedures.

21. A CMS-1500 - Health Insurance Claim Form - is used by providers to submit claims to the government for Medicare Part B services, and is used for most, if not all, fee-for-service health care benefit programs, whether public or private. [6] The CMS-1500 cautions the user that "filing a claim containing any misrepresentations, or any false, incomplete or misleading information, is subject to both criminal and civil penalties." In submitting this claim form, the provider is certifying that his or her services were rendered in compliance with Medicare regulations, including that the services were "medically indicated and necessary." No Medicare benefits may be paid unless the appropriate claim forms are submitted, as required by 42 C.F.R.§ 424.32.[7]

22. A CMS-843 - Certificate of Medical Necessity (CMN) Form - for motorized wheelchairs must be received by a supplier from a treating physician. Suppliers must have a faxed or copied version of the signed original CMN in their records before they can submit a claim for payment to Medicare. An original hardcopy, facsimile, photocopy, or an electronic CMN must be

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[5] DMERC Region D Supplier Manual, Chapter 14, Page 7, Revised 01/01.

[6] Previously known as a HCFA-1500 form.

[7] 42 C.F.R.§ 424.32 sets forth the basic requirements for all claims, including with whom claims must be filed and by whom claims must be signed. The regulation also requires that claims be filed within specified time limits and be submitted on prescribed forms, such as the CMS-1500.

maintained by the supplier and be available to the DMERC on request.[8] The CMN cautions the user that filing a claim which contains "any falsification, omission or concealment of material fact" may subject the physician to civil or criminal liability.[9]

23. Power wheelchairs are categorized by Medicare by five CPT codes: K0010, K0011, K0012, K0013, and K0014. The K0011 power wheelchair is the focus of this affidavit. A K0011 power wheelchair is a standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking.[10]

24. To qualify for a K0011, Medicare beneficiaries must meet three criteria as defined in the DMERC Region D Supplier Manual:

> 1. The patient's condition is such that without the use of a wheelchair, the patient would otherwise be bed or chair confined; and
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> 2. The patient's condition is such that a wheelchair is medically necessary and the patient is unable to operate the wheelchair manually; and
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> 3. The patient is capable of safely operating the controls for the power wheelchair.[11]

The DMERC Region D Supplier Manual also states in part:

> A patient who requires a power wheelchair usually is nonambulatory and has severe weakness of the upper

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[8] DMERC Region D Supplier Manual, Chapter 4, Page 1, Revised 01/01.

[9] CMS-843 Form, Section D, Revised 05/97.

[10] DMERC Region D Supplier Manual, Chapter 9, WCB - Page 1, Revised 01/01.

[11] DMERC Region D Supplier Manual, Chapter 9, WCB - Page 1, Revised 01/01.

extremities due to a neurologic or muscular disease/condition.[12]

25. Medicare mandates that a CMN be completed and signed by the beneficiary's treating physician before that beneficiary can qualify for a K0011 power wheelchair.[13] CMNs describe the required medical necessity information and can be submitted either on paper or in electronic form. The underlying and essential premise in Medicare's system for providing wheelchairs to beneficiaries is that physicians will honestly and truthfully complete CMNs.

26. A power operated vehicle (POV), CPT code E1230, is commonly referred to as a "scooter". To qualify for a scooter, the beneficiary must meet the same criteria as required for a power wheelchair with one additional requirement. The patient must be able to transfer safely in and out of the scooter and have adequate trunk stability to be able to safely ride in the scooter.[14]

27. Scooters are reimbursed by Medicare at a significantly lower rate than K0011 wheelchairs. The following chart compares the amount reimbursable from Medicare to DME suppliers for K0011 power wheelchairs and scooters.[15]

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[12] DMERC Region D Supplier Manual, Chapter 9, WCB - Page 1, Revised 01/01.

[13] DMERC Region D Supplier Manual, Chapter 4, Page 5, Revised 01/01.

[14] DMERC Region D Supplier Manual, Chapter 9, POV - Page 1, Revised 01/01.

[15] The amounts listed on the chart indicate the 80% reimbursement rate Medicare actually pays to suppliers. For those who qualify, Missouri Medicaid would reimburse the additional 20% to cover the entire cost of the K0011.

Year	Amount Reimbursable for K0011s	Amount Reimbursable for Scooters
2002	$4,216.24	$1,809.44
2003	$4,216.00	$1,809.44
2004	$4,237.20	$1,809.44
2005	$4,098.24	$1,809.44

VI. Execution of the Scheme to Defraud and Evidence of Fraudulent Conduct

28. CIGNA provided investigators with a record of all claims and billings submitted by Primecare from May 5, 2004, through September 30, 2005. The chart below reflects the total claims Primecare submitted for K0011 power wheelchairs and the total amount Medicare paid to Primecare for power wheelchair claims.

PRIMECARE	MEDICARE
Date of First Submitted K0011 Claim	May 7, 2004
Date of Last Submitted K0011 Claim	September 29, 2005
# of K0011 Claims Submitted	102
# of K0011 Claims Reimbursed	88
Amount Submitted	$561,000.00
Amount Reimbursed	$361,811.14

29. As of December 16, 2005, HHS agents had conducted seven (7) field interviews and thirty-five (35) telephonic interviews of Primecare beneficiaries who, according to Medicare records, were among the eighty-eight (88) beneficiaries for which Medicare paid Primecare

to provide a K0011 power wheelchair. Twenty-seven (27) of the forty-two (42) beneficiaries who were interviewed reported that they actually received a scooter, not the K0011 power wheelchair that was billed to Medicare and that Medicare paid Primecare to provide. The preliminary loss to Medicare represented by this small sampling alone is $110,913.32.

30. Legitimate DME supply companies have a diverse business that includes many other DME services such as bandages, braces, canes, and hundreds of other basic medical supplies. In rare instances, a legitimate DME supplier will concentrate efforts in one area such as wheelchairs, but these operations generally have large store fronts, extensive local advertising, and a network of contacts with rehabilitation centers where similarly-afflicted patients are concentrated. Primecare does not fit either of these descriptions of a legitimate DME company.

31. On December 15, 2005, while law enforcement agents from HHS and the FBI were executing a search warrant at a medical supply company located in the same building as Primecare,[16] agents sought and received consent from Kenneth Agugua to search the business premises of Primecare located at xxxxxxx. During the course of this consent search, the searching agents found no evidence that Primecare was a diverse business that offered many types of DME services, nor did the searching agents find any evidence to suggest that Primecare was engaged in extensive local advertising or had a network of contacts with rehabilitation centers. During the course of this consent search, Kenneth Agugua and Martin Okpareke both stated during non-custodial interviews that Primecare did not engage in paid advertising and that almost all of Primecare's "advertising" was done by word of mouth.

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[16] The search warrant was being executed at the business office of Prucare, located in xxxxxxxx, at xxxxxxxxxxxxxxxxxx, Kansas City, Missouri, the same building where Primecare is located. The search warrant is filed as Case No. xxxxxxxxx.

VII. Known Patterns of Fraud

32. The K0011 claims submitted by Primecare exhibit similarities with known patterns of fraud as discovered through similar DME investigations conducted by HHS and the Federal Bureau of Investigation (FBI).[17]

33. One pattern observed in fraudulent DME companies is that a majority of their referrals come from a single physician or a small group or number of physicians. Legitimate DME operations exhibit a more random pattern of referrals where there are nearly as many referring physicians as there are customers that walk into the medical supply store. Of the 102 K0011 claims submitted by Primecare between May 7, 2004, and September 30, 2005, seventy-five (75) of them listed Amazair McAllister as the referring physician (74% of the referrals) while twenty (20) of the claims listed Ambrose Wotorson as the referring physician (20% of the referrals). On December 15, 2005, both Wotorson and McAllister were arrested on warrants charging them by complaint with the crime of health care fraud. See Case No. 05-210-SWH-01/06, Western District of Missouri. The affidavit filed in support of said complaint recites hundreds of instances in which Wotorson and McAllister fraudulently and falsely completed CMNs for Medicare beneficiaries who were ambulatory and for whom a power wheelchair was not medically necessary. See Affidavit of FBI SA Rebekah Wiles, Case No. 05-210-SWH-01/06. In summary, not only do Primecare's billings match a known pattern of fraud in that 94% of its referrals are from only two physicians, but

[17] Medicare payments for power wheelchairs dramatically increased nationwide from $10 million in 1994 to $1.2 billion in 2003, with a 300 percent increase occurring between 2001 and 2003. As a result, federal law enforcement agencies throughout the United States have pursued numerous investigations and prosecutions pertaining to fraudulent claims for power wheelchairs.

those two referring physicians have been charged with committing health care fraud in connection with how the physicians complete the CMNs used to obtain power wheelchairs from Medicare.

34. A second pattern observed in fraudulent DME companies is the sudden onset of high-volume Medicare business within a short period of time. Primecare was incorporated on June 18, 2003. In just over seventeen months, from May 7, 2004, when Primecare submitted its first K0011 claim, through September 30, 2005, Primecare submitted a total of 431 claims to CIGNA, which totaled over $ 643,000 billed to Medicare and more than $ 400,000 paid by Medicare.

35. A third pattern observed in fraudulent DME companies is a concentration of claims in one particular CPT code. In the case of Primecare, just over 50% of the claims it submitted to CIGNA were concentrated in the codes for power wheelchairs and the batteries required for power wheelchairs.

36. A fourth pattern observed in fraudulent DME suppliers is the "recruiting" of Medicare beneficiaries. As explained in detail below, Primecare hired "recruiters" to go out and find Medicare beneficiaries and lure them to the Primecare office with the promise of a "free wheelchair."[18] This recruitment technique is in stark contrast to the usual progression of events in which an examining and/or treating physician first determines that it is medically necessary for his patient to have a wheelchair and the beneficiary then contacts a wheelchair supplier to order a wheelchair.

37. Jimmy Gravely was one of the recruiters hired by Primecare. During an interview of Gravely by agents from the FBI, Gravely stated that in February or March of 2005, he met Victoria, who was a recruiter for Primecare. Victoria introduced Gravely to "Ken," who was represented to be the owner of Primecare. "Ken" hired Gravely as a recruiter for Primecare. Gravely

[18] During the course of the December 15, 2005, consent search of the business premises of Primecare, agents found flyers that advertised scooters and power wheelchairs for free.

recruited approximately fifteen individuals for Primecare over the course of two or three weeks. Gravely was supposed to be paid approximately $50 to $75 per individual he recruited to receive a wheelchair, but he eventually left Primecare because he did not believe Ken was paying him enough.

VIII. Statements from the Fraud Scheme Participants

38. On December 15, 2005, Martin Okpareke gave a non-custodial interview to agents who were executing the consent search at xxxxxxxxx. During this interview, Okpareke confirmed that at one time he had worked as a recruiter for Primecare and that Jimmy Gravely also had worked as a recruiter for Primecare. Okpareke also identified by name other individuals who had worked as recruiters for Primecare in the past, and also identified by name other individuals who were currently working as recruiters for Primecare.

39. On December 15, 2005, Kenneth Agugua gave a non-custodial interview to agents who were executing the consent search at xxxxxxxxx. During this interview, Kenneth Agugua confirmed that Martin Okpareke worked for Primecare and described Okpareke's duties as being an agent/recruiter who contacts people in hospitals and in the community to see if they are interested in receiving a power wheelchair or scooter.

40. During this non-custodial interview, Kenneth Agugua also identified the four companies that Primecare uses to purchase power wheelchairs and scooters. A preliminary review of the Primecare business records taken during the December 15, 2005, consent search confirmed that at least 80% of the purchases Primecare made from these companies consisted of scooters rather than power wheelchairs.

41. A review of the business records taken during the December 15, 2005, consent search also document the involvement of Faith Agugua in the operation of Primecare as a business. For example, Faith Agugua is the only person who has signature authority on Primecare's business

checking account at Bank of America. In addition, checks made payable to a durable medical equipment company in Summit, Texas, for the purchase of power wheelchairs and scooters were signed by Faith Agugua.

42. During his December 15, 2005, statement, Martin Okpareke stated that he believed Faith Agugua was the owner of Primecare and that she signed the checks he received for the work he performed on behalf of Primecare.

43. During his December 15, 2005, statement, Kenneth Agugua identified himself as the office manager of Primecare. Business cards taken during the consent search state that Kenneth Agugua is an employee/representative of Primecare. Kenneth Agugua further stated that his job duties included ordering durable medical equipment and dealing with insurance and billing issues. Kenneth Agugua further stated that Faith Agugua is the owner of Primecare; that she was responsible for the day-to-day operation of the business; and that she was the overall administrator of the business. According to Kenneth Agugua, he and Faith Agugua were responsible for all billing and purchasing done by Primecare.

44. During their December 15, 2005, statements, both Kenneth Agugua and Martin Okpareke confirmed that Primecare most frequently relied upon Amazair McAllister and Ambrose Wotorson to complete the CMNs required in order to obtain a power wheelchair from Medicare. In addition, both Kenneth Agugua and Martin Okpareke denied that Primecare paid these doctors any money in return for the doctors completing the CMNs. Dr. Wotorson tells a different story. Following his arrest on December 15, 2005, and after signing a written waiver of his Miranda rights, Dr. Wotorson stated that he had been approached by Kenneth Agugua and Martin Okpareke who represented that they were acting on behalf of Primecare. Agugua and Okpareke then negotiated an agreement with Wotorson under which he would be paid a fee for every power wheelchair CMN

he signed for a Primecare client. Wotorson stated that following this agreement, he received weekly cash payments for the CMNs he signed for Primecare.

IX. Federal Criminal Offense

45. The facts set forth in this affidavit confirm that Faith Agugua and Kenneth Agugua are the only individuals that are authorized to bill Medicare on behalf of Primecare, and are the only two individuals who billed Medicare on behalf of Primecare. Further, Faith and Kenneth Agugua were the only individuals who ordered and purchased durable medical equipment on behalf of Primecare. A review of the Medicare billings submitted by Primecare confirms that Primecare has only billed Medicare for K0011 power wheelchairs and never billed Medicare for a scooter. Since the only item being billed was a K0011 power wheelchair, Primecare never should have delivered a scooter to any Medicare beneficiary. However, as documented through the interviews of Medicare beneficiaries, at least twenty-seven (27) of the eighty-eight (88) Medicare beneficiaries that Primecare was paid to provide a power wheelchair to, did not receive a power wheelchair but instead received a scooter. As the only Primecare employees who were responsible for billing Medicare, and the only Primecare employees who were responsible for ordering and purchasing durable medical equipment, Faith and Kenneth Agugua had to know that Primecare was billing Medicare for a more expensive item, *i.e.*, a power wheelchair, than the item that Primecare actually delivered, *i.e.*, a scooter.

46. Based on the facts set forth in this affidavit, affiant asks the court to conclude that there is probable cause to believe Kenneth Agugua and Faith Agugua have engaged in a scheme to defraud Medicare, in violation of 18 U.S.C. § 1347.

47. Affiant further asks that the Court issue warrants for the arrest of Kenneth Agugua and Faith Agugua

Under penalty of perjury, I swear that the foregoing is true and correct to the best of my knowledge, information and belief.

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Brian Hill
Special Agent
HHS-OIG-OI

Subscribed and sworn to before me this _____ day of December, 2005.

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Hon. John T. Maughmer
Chief United States Magistrate Judge